

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038674

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 148

FILED SEP 18 1963

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Nevada</b>		c. CITY OR TOWN <b>Butler</b>	
Length of stay in 1b <b>11 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #3</b>		d. STREET ADDRESS (If outside, give location) <b>406 Clark St.</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Thomas J. Hancock</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>7</b> Year <b>1963</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/1879</b>	9. AGE (last birthday) <b>83yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Butler, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Green Hancock</b>		13b. MOTHER'S MAIDEN NAME <b>Lucina Poindexter</b>	
14. NAME OF HUSBAND OR WIFE <b>Luvena (Cox) Hancock</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>NO</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>State Hospital records, Nevada, Mo.</b>		18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> Generalized Arteriosclerosis DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>[REDACTED]</b>		INTERVAL BETWEEN ONSET AND DEATH <b>yrs.</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Para-Phimosis</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>[REDACTED]</b> a.m. <b>[REDACTED]</b> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Butler Missouri</b>

21. Attended the deceased from <b>VIEWED THE BODY</b> and last saw her alive on <b>9-7-63</b> Death occurred at <b>4:44</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>Glenn D. Hughes M.D.</b>		22b. ADDRESS <b>STATE HOSP. - NEVADA, MO</b>		22c. DATE SIGNED <b>9-7-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/9/63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakhill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Butler Missouri</b>	
24. FUNERAL DIRECTOR <b>Culver Underwood, Butler Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-9-1963</b>		26. REGISTRAR'S SIGNATURE <b>Anna E. Perry</b>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert E. Sturibeck

Licensed Embalmer No. 4657

P. O. Address Battle, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Embalmer's Seal

Embalmer's Seal

Embalmer's Seal

Embalmer's Seal

Embalmer's Seal